

FILED FEB 11 1949

STANDARD CERTIFICATE OF DEATH

State File No. 1711

BIRTH NO. _____		REG. DIST. NO. 174		PRIMARY REG. DIST. NO. 3035		Registrar's No. 8			
1. PLACE OF DEATH a. COUNTY <u>LAFFAYETTE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>MISSOURI</u> b. COUNTY <u>LAFFAYETTE</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>LEXINGTON</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>LEXINGTON</u>		3			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>South Side Add. 1</u>				d. STREET ADDRESS (If rural, give location) <u>South Side Add.</u>					
3. NAME OF DECEASED (Type or Print)		a. (First) <u>NORA</u>		b. (Middle) <u>ALICE</u>		c. (Last) <u>GRAY</u>			
4. DATE OF DEATH		(Month) <u>1</u> (Day) <u>2</u> (Year) <u>1949</u>							
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>5-30-1881</u>			
9. AGE (In years last birthday) <u>67</u>		10. MONTHS <u>7</u> DAYS <u>2</u>		11. BIRTHPLACE (State or foreign country) <u>LAFFAYETTE Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____							
13a. FATHER'S NAME <u>EPH. BUTLER</u>		13b. MOTHER'S MAIDEN NAME <u>CARRIE SIMON</u>		14. NAME OF HUSBAND OR WIFE <u>CHAS. GRAY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>CHAS. GRAY</u> ADDRESS <u>LEX. Mo.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Poor Arterial Sclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____					
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>7/21</u> , 1948, to <u>Jan 2</u> , 1949, that I last saw the deceased alive on <u>Dec 24</u> , 1949, and that death occurred at <u>7:35 a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Ben H. Brasher, M.D.</u>				23b. ADDRESS <u>Lexington Mo.</u>		23c. DATE SIGNED <u>1-3-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>1-6-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mashpelah Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>LEXINGTON Mo.</u>			
DATE REC'D BY LOCAL REG. <u>1-26-1948</u>		REGISTRAR'S SIGNATURE <u>Wm. E. Enchurk</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>FORREST F. TEMPEL</u>		ADDRESS <u>LEX. Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 2-10-49

JAN 9 1959

Brusher

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Leo M. Leune

Licensed Embalmer No. 2983

P. O. Address Levinington Nw.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.